

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05246

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05244

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKridge Md.</u>		c. LENGTH OF STAY IN lb <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKridge Md.</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Run Creek-ELKridge-Howard</u>			d. STREET ADDRESS <u>RACE ROAD</u> <u>ELKridge Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES. NELSON BROOKS</u>			4. DATE OF DEATH Month Day Year <u>April 19 1967</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-20-1926</u> 47		9. AGE (In years and birth day) yrs. Months Days IF UNDER 1 YEAR IF UNDER 24 HRS. 19 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
13. FATHER'S NAME <u>HERMAN P. BROOKS.</u>			14. MOTHER'S MAIDEN NAME <u>MARY A. MCINTYRE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>219-10-3985</u>		17. INFORMANT <u>Howard Brooks</u> Address <u>3823 Calloway AVE Balto 21215 Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>9:50</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>while fishing fell in Stoney Run Creek.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>5:50 p.m. 4-19 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Run Cr. Elkridge Howard Md</u>	
20f. (City or town) (County) (State) <u>Elkridge Howard Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: <u>George E. Burtorf</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>4-19-67</u>	
EXAMINER'S NAME (Type) <u>George E. BURTORF MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>ELICITT CITY Md.</u>	
23a. BURIAL CREMATION, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law 802 Madison Ave., Balto., Md.</u>			
25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02834

02834

APR 3 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05247		05245	
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>87 N. ST John's Lane</u>		d. STREET ADDRESS <u>87 N. ST John's Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charlie E Brown</u>		4. DATE OF DEATH Month Day Year <u>4-5 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CREDIT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ORE.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lulu F. Isaacs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>564-05-1229</u>	
17. INFORMANT <u>ELEANORA BROWN</u>		Address <u>87 N. ST John's Ellicott City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OLD MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ASCVD-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>66</u> , to <u>4-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Peter V. Thoden</u>		22b. DATE SIGNED <u>4-6-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKEVIEW</u>	23d. LOCATION (City, town or county) (State) <u>Eldersburg, Md.</u>
24. FUNERAL DIRECTOR <u>Highbolton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C. 20250  
OFFICE OF THE SECRETARY

NOV 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (b) shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05248					05246				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Taylor Manor Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3507 Langrehr Rd., Apt. 1-C</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jack</u> Middle <u>Caplan</u> Last <u>Caplan</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>2</u> Year <u>19 67</u>						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/21/1900</u>		<b>9. AGE</b> (In years last birthday) <u>66</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETAIL MERCHANT</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RETAIL</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>RUSSIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>AARON CAPLAN</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>HANNAH MILLER</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>228109792</u>		<b>17. INFORMANT</b> <u>MRS. SARAH CAPLAN, 3507 LANGREHR ROAD, APT. 1-C</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>103X</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>103X</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/31</u> , 19 <u>67</u> , to <u>4/2/67</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Irving J. Taylor, M.D.</u>					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>4/2/67</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Irving J. Taylor, M.D.</u>					<b>22d. ADDRESS</b> <u>Taylor Manor Hospital, Ellicott City Md</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>4/3/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CHIZUK AMUNO (ARLINGTON)</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Swenson Bros. F.H.</u>					<b>ADDRESS</b> <u>Atk 6</u>		<b>25a. REC'D BY REGISTRAR</b> <u>1967</u>		
					<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

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RECEIVED

NO

1957



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05249

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05247

1. PLACE OF DEATH a. COUNTY <u>Howard Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Laurel</u>		c. LENGTH OF STAY IN lb <u>2 mos</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Laurel</u> <u>13-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u>			d. STREET ADDRESS <u>224 Gorman Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Madison Ellinger</u>			4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-95</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milk worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cottamill</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Ellinger</u>			14. MOTHER'S MAIDEN NAME <u>Frances</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>227-09-7876</u>	17. INFORMANT <u>Mrs Sarah A. Ellinger</u> Address <u>224 Gorman Rd. N. Laurel</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>4/2/67</u>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>44 Church Rd. Ellicott City, Md</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Madamridge Mem. Church</u>	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR <u>DeWitt Donaldson, Laurel, Md</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

058513

058513



05250

CERTIFICATE OF DEATH

05248

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1139 Frederick Rd.</b>		d. STREET ADDRESS <b>1139 Frederick Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Howard E. Harrison, Sr.</b>		4. DATE OF DEATH <b>April 11 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1894.</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrotyper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert W. Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McNeir</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-09-1925</b>	
17. INFORMANT <b>Mr. Howard E. Harrison, Jr.</b>		Address <b>Ellicott City, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Heart-block</b> DUE TO (c) <b>Coronary artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension, my. Parkinson's</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 19 <b>67</b> , to <b>4/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/11</b> , 19 <b>67</b> , and that death occurred at <b>9:11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Christian P. Mass</b>		22b. DATE SIGNED <b>4/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Christian Mass</b>		22d. ADDRESS <b>CHRISTIAN P. MASS, M.D. BALTIMORE NAT'L. PIKE &amp; ST. JOHN'S LANE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 1967</b>	
ADDRESS <b>5305 Harford Rd. #14</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02548

02520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05251						05249					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Howard</b>						a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>						b. COUNTY <b>Harford</b>					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryman</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Taylor Manor Hospital</b>						d. STREET ADDRESS <b>12-2</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			<b>Howard</b>			<b>S.</b>			<b>Holloway</b>		
4. DATE OF DEATH			Month			Day			Year		
			<b>April</b>			<b>27</b>			<b>19 67</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/27/80</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days	
										11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Practice</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Charles Coleman Holloway</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Gallup</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-46-1080</b>				17. INFORMANT <b>Catherine Taylor, Perryman, Maryland</b>			
								Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Arteriosclerotic Cardiovascular disease</b> cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome with senile brain disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 4, 1967</b> to <b>April 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1967</b> , and that death occurred at <b>5A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Stephen Lee Magness</b> 22c. PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness</b>						22b. DATE SIGNED <b>4/27/67</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Taylor Manor Hospital</b> <b>Ellicott City, Maryland 21042</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>29 Apr. 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Perryman, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Macomber Jr.</b>				25a. REC'D BY REGISTRAR <b>Tarling Funeral Home</b> <b>Aberdeen, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b> <b>MAY 1 1967</b>			

08249

CONTINUATION OF DEATH

08249

2

APR 15, 1955

Stephen Lee Morgan

Little Rock, Ark.

MAY 1, 1957

FOR STATE  
HEALTH DEPT.

05252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05250

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b> c. LENGTH OF STAY IN 1b <b>13 1/2</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. #216 - Hyde-Away Farm</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b> d. STREET ADDRESS <b>Route 216 - Hyde-Away Farm</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN P. HYDE</b>		4. DATE OF DEATH Month Day Year <b>4 30 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-18</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Consultant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>CLEARSPRING, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES A Hyde</b>		14. MOTHER'S MAIDEN NAME <b>BLANCHE RHODES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 11-42/11/45</b>		16. SOCIAL SECURITY NO. <b>225-10-8236</b>	
17. INFORMANT <b>Mrs Margaret A. Hyde</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>976X IMMEDIATE CAUSE (a) Gunshot wound of chest</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Was despondent and in ill health - Shot self in chest</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home - Barn</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>4 30 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fulton</b>		20f. (City or town) (County) (State) <b>Howard Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		22. DATE SIGNED <b>5-1-67</b>	
EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL-CREMATATION REMOVAL TO <b>May 4, 1967</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>St Paul Church Cemetery, Rt 40 Hagerstown Md</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Harold Swade, Laurel, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>MAY 1 1967</b>	

02370

82520



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 05251

05253

1. PLACE OF DEATH a. COUNTY <u>Howard County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Md.</u> b. COUNTY <u>Howard</u> 13.1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Howard Co - Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer's Conv. Retreat</u>		d. STREET ADDRESS <u>8 Rollingtop Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>IRMA</u> First Middle Last <u>JONES</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/13</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>3</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARIAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BECK</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BEADY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-9228</u>	
17. INFORMANT <u>Son</u>		Address <u>8 Rollingtop Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the liver</u> <u>1561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 - 2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 1967, to <u>April 9</u> , 1967, that I last saw the deceased alive on <u>April 5</u> , 1967, and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Taylor MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Ellicott City, Md</u> DATE SIGNED <u>4-9-67</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-12-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. [unclear]</u>		ADDRESS <u>Ellicott City, Md</u>	
24a. REC'D BY REGISTRAR <u>APR 11 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles [unclear]</u>	



CERTIFICATE OF DEATH

02251

02251

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. PLACE OF DEATH <i>Home</i>		10. TIME OF DEATH <i>10:30 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

05254

## CERTIFICATE OF DEATH

05252

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #29</b>		d. STREET ADDRESS <b>1533 Kingsway Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>J.</b> Last <b>LIEDER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1886.</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>23</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hermann</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Kuenley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-48-3494</b>	
17. INFORMANT <b>Mrs. Elizabeth L. Feltham</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm accident</b> DUE TO <b>Arteriosclerotic cerebrovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 yrs</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 1967, to <b>April 23</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 12</b> , 1967, and that death occurred at <b>5:15 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. Allan Spier</b>		22b. DATE SIGNED <b>4/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Allan Spier</b>		22d. ADDRESS <b>1501 Kim Pentridge Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>4/26/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jorgensen</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02525

UNIVERSITY OF CALIFORNIA

02525

Name		Address		City		State		Zip	
John Doe		123 Main St		Los Angeles		CA		90001	
Jane Smith		456 Oak Ave		San Francisco		CA		94102	
Bob Johnson		789 Pine St		New York		NY		10001	
Alice Brown		101 Elm St		Chicago		IL		60601	
David White		202 Maple St		Houston		TX		77001	
Susan Green		303 Cedar St		Phoenix		AZ		85001	
Michael Black		404 Birch St		Seattle		WA		98101	
Emily Davis		505 Spruce St		Portland		OR		97201	
Christopher Lee		606 Willow St		Denver		CO		80201	
Stephanie Hall		707 Ash St		San Diego		CA		92101	
Daniel King		808 Hickory St		Austin		TX		78701	
Olivia Young		909 Walnut St		Nashville		TN		37201	
Nathan Scott		1010 Cherry St		Boston		MA		02101	
Sophia Adams		1111 Peach St		San Jose		CA		95101	
Ethan Baker		1212 Apple St		Dallas		TX		75201	
Isabella Nelson		1313 Banana St		San Antonio		TX		78201	
Liam Hill		1414 Orange St		Fort Worth		TX		76101	
Mia Garcia		1515 Grape St		Columbus		GA		31901	
Noah Martinez		1616 Lemon St		Indianapolis		IN		46201	
Charlotte Lopez		1717 Lime St		Jacksonville		FL		32201	
Caleb Wilson		1818 Coconut St		San Luis Obispo		CA		93401	
Hannah Moore		1919 Coffee St		Fresno		CA		93701	
Isaac Taylor		2020 Tea St		Bakersfield		CA		93301	
Layla Anderson		2121 Sugar St		Stockton		CA		95201	
Oscar Thomas		2222 Honey St		Modesto		CA		95350	
Penelope Jackson		2323 Butter St		Yuba City		TX		79601	
Ryder Roberts		2424 Oil St		Merced		CA		95340	
Valentina Clark		2525 Vine St		Tulare		CA		95380	
Wyatt Lewis		2626 Olive St		Visalia		CA		93278	
Zoe Walker		2727 Poplar St		Hanford		CA		93230	
Adam Hall		2828 Cotton St		Corcoran		CA		93210	
Evelyn Young		2929 Walnut St		Wasco		CA		93280	
Gabriel King		3030 Cherry St		Arvin		CA		93203	
Harper Scott		3131 Peach St		Lemoore		CA		93245	
Ivy Adams		3232 Apple St		Reedley		CA		93274	
Jaxon Baker		3333 Banana St		Delmar		CA		93823	
Kaitlyn Nelson		3434 Orange St		Burrell		CA		93208	
Leo Hill		3535 Grape St		Manteca		CA		95330	
Mabel Garcia		3636 Lemon St		Camarillo		CA		93601	
Nolan Martinez		3737 Lime St		Santa Maria		CA		93455	
Olivia Lopez		3838 Coffee St		Santa Barbara		CA		93101	
Percy Taylor		3939 Tea St		Goleta		CA		93401	
Quinn Anderson		4040 Sugar St		Paso Robles		CA		93446	
Rory Thomas		4141 Honey St		Arroyo Grande		CA		93422	
Sage Jackson		4242 Butter St		Pittsburg		CA		95650	
Tara Roberts		4343 Oil St		Livermore		CA		94550	
Uma Clark		4444 Vine St		Hayward		CA		94541	
Victor Lewis		4545 Olive St		Union City		CA		94586	
Wendy Walker		4646 Poplar St		Fremont		CA		94536	
Xavier Hall		4747 Cherry St		Oakland		CA		94612	
Yara Young		4848 Peach St		Berkeley		CA		94702	
Zoe Adams		4949 Apple St		Albany		CA		94706	
Aaron Baker		5050 Banana St		San Francisco		CA		94102	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05255

CERTIFICATE OF DEATH

05253

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lark Brown, Road</b>		d. STREET ADDRESS <b>Lark Brown Rd,</b>	
3. NAME OF DECEASED (Type or print) <b>Abraham Matthews</b>		4. DATE OF DEATH <b>April 21 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/ 75</b>
9. AGE (In years lost birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co, Md</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular disease</b> DUE TO (b) <b>conformities of age</b> DUE TO (c) <b>10 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>April 1967</b> , that (I) (we) lost the deceased alive on <b>April 20 1967</b> , and that death occurred at <b>12:30 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>B B Brumbaugh</b>		22b. DATE SIGNED <b>4-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		22d. ADDRESS <b>3609 main st Ellicott City Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05256

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05254

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R. Clarksville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pindate School Rd.</b>			d. STREET ADDRESS <b>42 Evergreen Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Patrick</b> Last <b>Phelps</b>			4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-49</b>		9. AGE (In years last birthday) <b>18</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High school</b>		11. BIRTHPLACE (State or foreign country) <b>London, England</b>	
13. FATHER'S NAME <b>Richard J. Phelps</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Boone</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bernard Butling</b> Address <b>Alhane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head Injury Severe -</b> DUE TO (b) <b>Trauma from Auto Accident.</b> stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car ran off Rd. and Struck a Pole</b>			
20c. TIME OF INJURY Month, Day, Year <b>8:45 p.m. 4/13 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
		20f. (City or town) <b>R. Clarksville</b>		(County) <b>Howard</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John S. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John S. Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4/14/67</b>		
			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City or Town) <b>Calmar Manor Md</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Wm. W. Wm. Wm.</b>		ADDRESS <b>General Md</b>		25a. REC'D BY REGISTRAR DATE <b>20 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



02250

02250

02250-100

R 2000-1-10

Private School R21

10000

10000

10000

Hand In July 2000 -  
Trenton, from AUSA's accident

Residence in Canton off 21 and 22nd St. N.Y.C.

R Clarkville Howard Ave

X Highway 1

800 - 4112-03

X 4/14/02

John M. Black



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05257					05255									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		Howard			a. STATE		Md.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Rural - Ellicott City			b. COUNTY		Howard							
c. LENGTH OF STAY IN 1b		Life			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Rural - Ellicott City							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Route 144			d. STREET ADDRESS		Route 144							
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)							
Bessie B Pickett					April 11 8 1967		71 yrs.							
6. SEX		7. COLOR OR RACE		8. MARRIED		9. OATE OF BIRTH		10. AGE (In years last birthday)						
Female		White		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-10-1895		71 yrs.						
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country)		14. CITIZEN OF WHAT COUNTRY?					
Housewife					Home		Maryland		U.S.A.					
15. FATHER'S NAME					16. MOTHER'S MAIDEN NAME									
Joseph H. Grimes					Mary Hipsley									
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					18. SOCIAL SECURITY NO.					19. INFORMANT Address				
No					-					MR. Earl Pickett - Ellicott City, Md.				
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis										142820				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardiac Vascular Disease										10 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 1-10, 1958, to 4-8, 1967, that (II) (we) last saw the deceased alive on 4-3, 1967, and that death occurred at 5A.M. from the causes and on the date stated above.														
22a. SIGNATURE Thomas F. Herbert					22b. DATE SIGNED 4-8-67									
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.					22d. ADDRESS 44 Chandler Rd., Ellicott City, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 4-10-67					23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery				
23d. LOCATION (City, town or county) (State) Howard Co. Md.					25a. REC'D BY REGISTRAR APR 12 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				
24. FUNERAL DIRECTOR Harry W. Haight					ADDRESS Sykesville, Md.									

03525

03525



APR 12 1967

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05256

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City 13-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Farm, Owen Brown Rd. &amp; Rt. 29</b>		d. STREET ADDRESS <b>16 Allview Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SMITH H. PURDUM</b>		4. DATE OF DEATH Month Day Year <b>April 9 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1903</b>
9. AGE (In years lost birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptroller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Smith W. Purdum</b>		14. MOTHER'S MAIDEN NAME <b>Laura</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-01-9633</b>	
17. INFORMANT <b>Alice Purdum, 16 Allview Dr., Ellicott City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Exposed self to CO fumes from tractor using rubber hose.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>4/ 8 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Ellicott City Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>4/9/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 13, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mettowee Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pawlett Vermont</b>	
24. FUNERAL DIRECTOR <b>Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05259					05257				
1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>13-1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>51 N. Rogers Ave.</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>51 N. Rogers Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ANNIE IRENE RADCLIFFE</b>			4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1967</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1880</b>	9. AGE (In years last birthday) <b>87</b> yrs.	10. UNDER 1 YEAR Months <b>8</b>	11. UNDER 24 HRS. Days <b>18</b>	12. HOURS <b>18</b>	13. MIN. <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ellicott City, Md</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Samuel E. Radcliffe</b>				14. MOTHER'S MAIDEN NAME <b>Addie Cassidy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-48-9779</b>		17. INFORMANT <b>Mrs. Lucy Owen, 51 N. Rogers Ave. E. C. Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222 Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic myocardial disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-22</b> , 19 <b>59</b> , to <b>4-18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-17</b> , 19 <b>67</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas F. Herbert</b>				22b. DATE SIGNED <b>4-20-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, MD</b>			
22d. ADDRESS <b>44 Church St. Ellicott City, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		23d. LOCATION (City, town or county) (State) <b>Ellicott City, Md</b>			
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1000



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05260

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05258

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN lb <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>302 W Main Street</u>		d. STREET ADDRESS <u>122 Oakdale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ella E.O. Reichenbecker</u>		4. DATE OF DEATH <u>4-30-67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l Business Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CTP Tel. Co.</u>	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Francis Bayard Clark</u>		14. MOTHER'S MAIDEN NAME <u>Frances Donovan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-6187</u>	
17. INFORMANT <u>C.H. Reichenbecker</u>		Address <u>122 Oakdale Ave. Catonsville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>147 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>5-1-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>444 Church Rd. Ellicott City, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>EL LICOTT CITY, MD</u>	
24. FUNERAL DIRECTOR <u>Easton Funeral Home Catonsville</u>		25a. REC'D BY REGISTRAR <u>MAJ 3 1967</u>	
ADDRESS <u>Md. 21228</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Medical Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05261

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05259

1. PLACE OF DEATH a. COUNTY <u>HOWARD CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COOKSVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT. 97</u>		d. STREET ADDRESS <u>RT 97</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SEISER</u> Last <u>SEISER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-17-1888</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>THOMAS PRUCHA</u>		14. MOTHER'S MAIDEN NAME <u>JOSEFINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ELEANOR DEVESE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma gallbladder severe</u> DUE TO (b) <u>liver enlargement, cirrhosis,</u> DUE TO (c) <u>severe icterus, bronchial pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <u>26 Feb 67</u> <u>to</u> <u>4-12-67</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>26 Feb, 1967</u> to <u>4-12, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-12, 1967</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>4-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL MD</u>		22d. ADDRESS <u>SYKESVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURN</u>		23b. DATE THEREOF <u>4/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LODGEON PK.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO.</u> <u>MD</u>	
24. FUNERAL DIRECTOR <u>E.S. Mac Nab</u>		25a. REC'D BY REGISTRAR <u>APR 17 1967</u>	
ADDRESS <u>BALTO 21228 MD</u> <u>301 FREDERICK RD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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05262

## CERTIFICATE OF DEATH

05260

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Hazel</b> Middle <b>M.</b> Last <b>Treadwell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/1919</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Marion, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Spicer</b>		14. MOTHER'S MAIDEN NAME <b>Madaloy Thonas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>230-28-8690</b>	
17. INFORMANT <b>John T. Treadwell</b>		Address <b>Clarksville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> DUE TO (b) <b>ABDOMINAL CARCINOMATOSIS</b> DUE TO (c) <b>SQUAMOUS CELL CARCINOMA OF CERVIX</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>6 MONTHS</b> <b>1 YEAR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/23, 1966</b> to <b>4/11, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/11, 1967</b> , and that death occurred at <b>3:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Charles S. Whitaker</b>		22b. DATE SIGNED <b>4/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		22d. ADDRESS <b>CLARKSVILLE, MD 21029</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Full Gospel Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Lisbon, Md.</b>
24. FUNERAL DIRECTOR <b>F.C. Higinbotham</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
ADDRESS <b>Ellicott City, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 05-11-2001 BY 60322 UCBAW/BJS

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05261

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> 03.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1, N. of Rt. 175</b>			d. STREET ADDRESS <b>8600 Church Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>MARSHALL Vogel Vogel</b>			4. DATE OF DEATH <b>Month Day Year</b> <b>April 8 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1918</b>	9. AGE (In years lost birthday) yrs. <b>49</b>	10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Berlin, Penna.</b>	
13. FATHER'S NAME <b>Henry Vogel</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			14. MOTHER'S MAIDEN NAME <b>Nellie Garlitz</b>		17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		22. DATE SIGNED <b>4/8/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>	23d. LOCATION (City or Town) (County) (State) <b>Randallstown, Md. 21133</b>		
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>APR 12 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

MEDICAL CERTIFICATION

02361

02361

APR 12 1967



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05264

05262

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mariottsville Road</b>		d. STREET ADDRESS <b>795 Yale Avenue 21229</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER CLARENCE WINDLE</b>		4. DATE OF DEATH Month Day Year <b>4 2 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-1896</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Clarence W Windle</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>705 03 5357</b>	
17. INFORMANT <b>Elmer J Windle</b>		Address <b>766 Yale Ave. Balto. Md. 29</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>4-3-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-6-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>
24. FUNERAL DIRECTOR <b>Thomas J Kenny Inc 1600 Hollins Balto Md</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles JUDGE</b>	

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